

SECTION 10: EMOTIONAL/SEXUAL HEALTH CARE

Concern	Care/Test	Frequency
Emotional/Sexual Health Care	♦ Assess emotional health; screen for depression	Each focused visit
	♦ Assess sexual health concerns	Each focused visit

Depression and Other Psychological Disorders

Depression is the most frequently cited psychological disorder associated with diabetes. It is roughly three times more prevalent in those with diabetes (15-20% of people) than in those without diabetes. The cause of increased instances of depression in people with diabetes is unknown; there is no evidence that diabetes, itself, *causes* depression. Depression in people with diabetes, in addition to the normally cited psychological complications leading to depression, may be aggravated by the challenge of adopting the wide-ranging medical regimens and lifestyle changes required of good diabetes self-management.

Evidence linking depression to both Type 1 and Type 2 diabetes complications continues to accumulate. Depression has been directly associated with poor glycemic control and can also contribute to poor lifestyle choices which further increase the risk for poor health, such as overweight and obesity, physical inactivity, substance abuse, and tobacco use.

Major depression is a disorder characterized by a cluster of mental and physical changes, all of which may persist and worsen over an extended period of time. People with diabetes experiencing major depression are usually unable to adhere to meal plans, testing schedules, and activity recommendations, leading to high blood sugar levels which increase the risk of long-term complications. The following changes characterize symptoms of depression:

- Decreased ability to cope with changes or challenges in life.
- Changes in crying patterns.
- Changes in sleeping and eating patterns.
- Changes in ability to concentrate.
- Changes in sexual desire.
- Increased pessimism.
- Sense of helplessness.
- Thoughts of death or suicide.
- Severe sadness.
- Loss of interest in usual activities.

It is important for providers in clinical practice to be aware of the potential for depression. Providers may mislabel lack of attention to diabetes self-care as non-compliant behavior when, in fact, it may indicate the need to screen for depression. Early recognition of depression symptoms, prompt treatment, and referral may lead to improved diabetes self-care and quality of life. Since people with diabetes may also have recurrent periods of depression, ongoing assessment or reassessment is essential.

Depression Screening

Depression screening tools can assist primary care providers in identifying depressive symptoms and determining whether treatment is necessary. The simplest, most direct and sensitive screening measure is the following two questions: 1) “Over the past two weeks, have you ever felt down, depressed, or hopeless?” and 2) “Have you felt little interest or pleasure in doing things?” There are other screening tools that may be useful in a clinical setting (see Table 14).

Table 14: Depression Screening Tools

Name of Test	Contact Information	Other Information
Beck Depression Inventory (BDI): <i>Fast Screen for Medical Patients</i> (for adolescents and adults)	Psychological Corporation Harcourt Assessment P.O. Box 839954 San Antonio, TX 78283-3954 (800) 211-8378 http://www.psychcorp.com	Complete kit (including manual and 25 record forms), \$75.
Patient Health Questionnaire-9 (PHQ-9), adapted from <i>PRIME-MD Today</i> , developed by Spitzer, Williams, Kroenke, and colleagues	See your Pfizer pharmaceutical representative	No charge. Reproduction permitted for the purposes of clinical care and research only.
Postpartum Depression Screening Scale by Cheryl Beck at the University of Connecticut	Western Psychological Services 12031 Wilshire Boulevard Los Angeles, CA 90025-1251 (310) 478-2061 http://www.wpspublish.com (type “Postpartum depression screening scale” into search box)	Complete kit (including 25 test forms and manual), \$68.50.
Wisconsin Association of Perinatal Care CES-D	Available at: http://www.perinatalweb.org/association/topic_depressionlink.html	No charge.

Treatment

While there is little information linking treatment of depression in people with diabetes to a faster recovery, outcomes are clearly enhanced by treatment. In fact, there is evidence that increased understanding of depression and its treatment modalities directly correlates with an increased adherence to provider recommendations.

Treatment with pharmacological agents and/or other therapeutic approaches can lead to improvements in self-management, glycemic control, adherence to recommendations, functionality, and quality of life. Some people may benefit from a combination of both pharmacological agents and short-term psychotherapy.

Note that the use of new, second generation anti-psychotic medications in people may exacerbate glycemic control problems, due to a potential side effect of weight gain.

Mental health professionals, particularly those professionals familiar with diabetes, can offer appropriate education, support, and treatment for depression.

Other Psychological Disorders

People with diabetes can also experience the following psychological disorders:

- Anxiety (i.e., generalized anxiety disorder, obsessive-compulsive disorder).
- Stress and stress-related disorders (i.e., adjustment disorder, eating disorder).
- Other mental disorders (i.e., personality disorders, schizophrenia, and other psychoses).

Special attention is needed to differentiate psychological problems from diabetes-related symptoms. Frequently, symptoms of psychological disorders can mimic symptoms of diabetes or typical diabetes care (i.e., hyperglycemia symptoms can be similar to symptoms of depression or anxiety disorders, and a focus on eating can be either healthy, attentive self-care or an early sign of an eating disorder).

Anxiety

Clinical anxiety is another problem common to people with diabetes that can interfere with effective diabetes management. Symptoms of clinical anxiety include restlessness, feeling on edge, fatigue, difficulty concentrating, irritability, muscle tension, and sleep disturbance. People experiencing anxiety may also describe an intense fear of hypoglycemia, or may not take the required amount of medication or insulin to adequately control blood sugar levels. Other fears or anxieties may focus on injections and testing blood glucose levels. Both anxiety and obsessive-compulsive disorders can compromise glycemic control.

Stress

People with diabetes must deal with the challenges of diabetes in addition to the stresses that are a part of everyday life in our culture. Feelings of frustration because of the 24/7 nature of self-care is common. In addition, newly diagnosed individuals can be fearful or concerned about the impact of the disease on an already difficult job or family situation. Emotional, physiological, and behavioral reactions to stress can lead to a deterioration of glycemic control. When stress hormones are released, the liver produces more glucose, blood pressure elevates, heart rate elevates, cortisol increases, and the immune system is compromised. An increase in diabetes self-management, as well as training in problem-solving and coping skills, can help people reduce stress. For severe cases, intensive treatment, such as psychotherapy or anti-anxiety medications, may be required.

Eating Disorders

Both types of eating disorders, anorexia nervosa and bulimia nervosa, affect people with diabetes. Eating disorders appear most frequently in young women with Type 1 diabetes. Anorexia nervosa involves a severe, self-imposed restriction of food coupled with high levels of physical activity. Bulimia nervosa involves binge eating followed by purging (vomiting). Bulimia will also frequently involve the use of diuretics and laxatives. Insulin manipulation due to varied food intake can increase the risk of poor glycemic control. Early detection and referral to a specialist is essential.

Psychosocial Factors Associated with Diabetes

There are other psychosocial factors that can be crucial to understanding a person's reaction to diagnosis, as well as his/her ability to self-manage and adhere to recommendations.

Psychosocial factors may contribute to a lack of energy or motivation, an inability to attain or maintain optimal blood sugar control, such as feelings of anger, grief, fear, frustration, guilt, and embarrassment. Understanding these psychosocial factors and other reactions to diabetes (denial and obsession) can play a significant role in treating the underlying issues that negatively impact the treatment and management of diabetes. Providers can encourage discussion and ask questions that assess coping ability. Maximizing effective self-help opportunities, positive coping strategies, and various therapies may help people address their negative emotions/reactions more effectively.

People with Type 1 diabetes bring with them a history shaped in part by all of the following: various circumstances surrounding their diagnosis and treatment, the reaction of family, friends, teachers, and coaches to their diagnosis, and the kind of supportive education received about diabetes. A child who was taught to be secretive and ashamed of his/her diagnosis will carry those feelings into adulthood, just as a child who never learned self-management may feel helpless as an adult.

Similarly, people with Type 2 diabetes may feel angry or responsible for “causing” their diabetes. They may feel that family members act as the “diabetes police” and food has become a battleground. How they learned of their diagnosis, their misconceptions, and their experience with others who have diabetes may form or alter their ability to cope, learn, and self-manage.

Sexual Health Concerns

Sexual dysfunction for people with diabetes is commonly caused by autonomic neuropathy. Sexual problems are common, and can affect approximately 75% of men and 35% of women with diabetes. The most common sexual problem for men is impotence and retrograde ejaculation. Impotence is an impairment or loss of erectile ability sufficient for intercourse with normal libido. Retrograde ejaculation is less common and results in damage to the efferent sympathetic nerves that normally coordinate the closure and relaxation of the internal and external vesicle sphincters. The most common sexual difficulties for a woman involve problems with arousal, decreased vaginal lubrication during stimulation, and anorgasmia despite normal libido. It is important for providers to inquire about the possibility of sexual concerns for both men and women, offer referrals to a specialist for diagnosis and counseling, and to review therapeutic options. Sexual difficulties may not always be related to autonomic neuropathy, such as loss of libido, which can be related to depression. Women can also experience more frequent yeast infections or other vaginal infections with diabetes, which can contribute to sexual difficulties.

Essential Patient Education for People with Emotional and Sexual Health Concerns

Because there are still many myths about depression, it is important to help people understand that depression is a treatable disease. Culturally appropriate approaches and materials should be used as needed. An assessment of literacy level can determine the best educational strategy or learning style to use. Education should include, but is not limited to, the following:

- Explain that depression is often associated with low energy levels, low motivation, and low self-esteem, all of which are factors contributing to diminished self-care.
- Provide emotional support and counter self-blame, especially when the person is unable to adequately self-manage or control blood sugars during a major depressive episode.

- Encourage people to take medication routinely and as prescribed (not stopping without first speaking to medical provider). Encourage treatment follow-up to assess responsiveness, check side-effect profile, titrate medications as needed, and provide continued support.
- Assess social support system and the level of practical and emotional support it provides.
- Discuss and offer ideas for community resources (i.e., a local support group).
- Advise additional self-management support and/or education as emotional health improves.
- Inquire about sexual health concerns, as people find it difficult to initiate this type of conversation.

Helpful Tools Included in this Section

- Patient Health Questionnaire (PHQ-9)
- PHQ-9 Quick Depression Assessment – Instructions for Use

Additional Resources

- 1) Surwit, RS, Bauman, A. *The Mind Body Diabetes Revolution: A Proven New Program for Better Blood Sugar Control*. New York, NY: Free Press; 2004.
- 2) Rubin, RL, Biermann J, Toohey B. *Psyching Out Diabetes: A Positive Approach to Your Negative Emotions*. 3rd ed. Lincolnwood, IL: Lowell House; 1999.
- 3) National Institute of Mental Health. Phone (301) 443-4513 or search NIMH's home page. Web site located at: www.nimh.nih.gov.

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- 2) Rubin RR, Peyrot, M. Psychological issues and treatments for people with diabetes. *J Clin Psychol*. 2001;57:457-478.
- 3) Surwit RS, van Tilburg MA, Zucker N, et al. Stress management improves long-term glycemic control in type 2 diabetes. *Diabetes Care*. 2002;25:30-34.
- 4) American Diabetes Association; American Psychiatric Association; American Association of Clinical Endocrinologists; North American Association for the Study of Obesity. Consensus development conference on antipsychotic drugs and obesity and diabetes. *Diabetes Care*. 2004;27:596-601.
- 5) Grossman H. Misplacing empathy and misdiagnosing depression. How to differentiate among depression's many faces. *Geriatrics*. 2004;59:39-41.
- 6) Van Voorhees BW, Cooper LA, Rost KM, et al. Primary care patients with depression are less accepting of treatment than those seen by mental health specialists. *J Gen Intern Med*. 2003;18:991-1000.
- 7) Iglehart JK. The mental health maze and the call for transformation. *N Engl J Med*. 2004;350:507-514.
- 8) Sherman SE, Chapman A, Garcia D, Braslow JT. Improving recognition of depression in primary care: a study of evidence-based quality improvement. *Jt Comm J Qual Saf*. 2004;30:80-88.
- 9) Polonsky WH, Parkin CG. Depression in patients with diabetes: seven facts every health-care provider should know. *Practical Diabetology*. Dec 2001:20-29.
- 10) Katon W, von Korff M, Ciechanowski P, et al. Behavioral and clinical factors associated with depression among individuals with diabetes. *Diabetes Care*. 2004;27:914-920.
- 11) Spitzer, Williams, Kroenke, et al. *Patient Health Questionnaire – PHQ-9*. PRIME-MD TODAY. Pfizer, Inc., 1999.
- 12) Zung W. *The Measurement of Depression*. 60-FL-1700-4. Eli Lilly and Company, 1998.
- 13) Lowe B, Unutzer J, Callahan CM, Perkins AJ, Kroenke K. Monitoring depression treatment outcomes with the Patient Health Questionnaire-9. *Med Care*. 2004;42:1194-1201.
- 14) Van Tilburg MA, McCaskill CC, Lane JD, et al. Depressed mood is a factor in glycemic control in type 1 diabetes. *Psychosom Med*. 2001;63:551-555.

- 15) Department of Health and Human Services, Public Health Service, National Institutes of Health. *Depression and Diabetes*. Publication No. 02-5003, May 2002.
- 16) de Groot M, Anderson R, Freedland KE, Clouse RE, Lustman PJ. Association of depression and diabetes complications: a meta-analysis. *Psychosom Med*. 2001;63:619-630.
- 17) Finkelstein EA, Bray JW, Chen H, et al. Prevalence and costs of major depression among elderly claimants with diabetes. *Diabetes Care*. 2003;26:415-420.
- 18) Jacobson AM. The psychological care of patients with insulin-dependent diabetes mellitus. *N Engl J Med*. 1996;334:1249-1253.

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME: _____

DATE: _____

Over the last two weeks, how often have you been
Bothered by any of the following problems?
(use “✓” to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual.	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself in some way.	0	1	2	3

add columns:

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(Healthcare professional: For interpretation of TOTAL,
please refer to accompanying score card.)

TOTAL:

10. If you checked off *any* problems, how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all _____
Somewhat difficult _____
Very difficult _____
Extremely difficult _____

Provided as a service by Pfizer Neuroscience

PHQ-9 is adapted from PRIME MD TODAY, developed by Drs Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke, and colleagues, with an educational grant from Pfizer Inc. For research information, contact Dr Spitzer at rls@columbia.edu. The names PRIME-MD® and PRIME MD TODAY™ are trademarks of Pfizer Inc.

PHQ-9 QUICK DEPRESSION ASSESSMENT – INSTRUCTIONS FOR USE
for doctor or healthcare professional use only

For initial diagnosis:

1. Patient completes PHQ-9 Quick Depression Assessment
2. If there are at least 4 ✓s in the gray highlighted section (including Questions #1 and #2), consider a depressive disorder. Add score to determine severity.
3. Consider Major Depressive Disorder
 - ♦ if there are at least 5 ✓s in the gray highlighted section (one of which corresponds to Question #1 or #2)Consider Other Depressive Disorder
 - ♦ if there are 2-4 ✓s in the gray highlighted section (one of which corresponds to Question #1 or #2)

Note: Since the questionnaire relies on patient self-report, all responses should be verified by the clinician, and a definitive diagnosis is made on clinical grounds taking into account how well the patient understood the questionnaire, as well as other relevant information from the patient. Diagnoses of Major Depressive Disorder or Other Depressive Disorder also require impairment of social, occupational, or other important areas of functioning (Question #10) and ruling out normal bereavement, a history of a Manic Episode (Bipolar Disorder), and a physical disorder, medication, or other drug as the biological cause of the depressive symptoms.

**To monitor severity over time for newly diagnosed patients
or patients in current treatment for depression:**

1. Patients may complete questionnaires at baseline and at regular intervals (e.g., every 2 weeks) at home and bring them in at their next appointment for scoring or they may complete the questionnaire during each scheduled appointment.
2. Add up ✓s by column. For every ✓: "Several days" = 1, "More than half the days" = 2, "Nearly every day" = 3.
3. Add together column scores to get a TOTAL score.
4. Refer to the accompanying PHQ-9 Scoring Card to interpret the TOTAL score.
5. Results may be included in patients' files to assist you in setting up a treatment goal, determining degree of response, as well as guiding treatment intervention.

PHQ-9 SCORING CARD FOR SEVERITY DETERMINATION

for healthcare professional use only

Scoring – add up all checked boxes on PHQ-9

For every ✓: Not at all = 0; Several days = 1; More than half the days = 2; Nearly every day = 3

Interpretation of Total Score

Total Score	Depression Severity
1 – 4	Minimal depression
5 – 9	Mild depression
10 – 14	Moderate depression
15 – 19	Moderately severe depression
20 – 27	Severe depression